STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING _____ B. WING _____	R-C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT VILLA NURSING AND REHABILITATION CENTER	545 W MOONGLO RD SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the PSR (Post Survey Revisit) to the Recertification and State Licensure Survey completed on 01/23/12 . This visited included the PSR to the Investigation of Complaint IN00102017 and IN00101919. Complaint IN00102017 - Corrected Complaint IN00101919 - Corrected Survey Date: February 27, 2012 Facility number: 000168 Provider number: 155267 Aim number: 100267020 Survey Team: Donna Groan, RN, TC Dorothy Navetta, RN Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 12 Medicaid: 41 Other: 10 Total: 63 Sample: 11 Scott Villa Nursing and Rehabilitation Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 and the PSR to the Investigation of Complaint IN00101919 and IN00102017. Quality review completed 2/28/12 Cathy Emswiller RN	{F 000}		